

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034633

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

317

Primary Registration District No.

544

Registrar's No.

2624

FILED SEP 4 1963

1. PLACE OF DEATH

a. COUNTY **St. Louis**

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN **Kirkwood**

Length of stay in lb
3 Yrs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION **Bethesda-Dilworth N.Home**

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **St. Louis**

c. CITY
OR
TOWN **Maplewood**

Inside Limits
Yes ☒ No ☐

d. STREET
ADDRESS **7747 Weaver Ave.**

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

EDITH

MAE

SCOTT

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

2-28-1879

9. AGE (last birthday)

84

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (City and state or country)

St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Isaac Cook

13b. MOTHER'S MAIDEN NAME

Mary E. Waring

14. NAME OF HUSBAND OR WIFE

Samuel P. Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) **No**

16. SOCIAL SECURITY NO.

17. INFORMANT

Peter W. Cook, Maplewood 43, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage left

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

DUE TO (b)

Arteriosclerotic vascular

DUE TO (c)

disease

Chr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Total blindness since 3 yrs.

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **Aug 1961** to **Aug 18 '63** and last saw her alive on **Aug 15 1963**
Death occurred at **12:20 a.m.** of the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

M.D.

22b. ADDRESS

**105 W. Lockwood Ave.
St. Louis 19, Mo.**

22c. DATE SIGNED

8-19-63

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE

8-19-1963

23c. NAME OF CEMETERY OR CREMATORY

Local Cemetery

23d. LOCATION (City, town, or county)

Whitesville, Mo.

24. FUNERAL DIRECTOR

ADDRESS

JAY B. SMITH, Maplewood 43, Mo.

25. DATE RECD. BY LOCAL REG.

8-19-63

26. REGISTRAR'S SIGNATURE

J. B. Smith

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

ITEM NO.

DATE AMENDED

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

100100-000

ODSeabaugh MD

WO 1-5002

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.